Employer Solutions Staffing Group LLC

7301 Ohms Lane / Suite 405
Edina, MN 55439
T:952.835.1288 / F:952.835.4881

New Hire Application

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Fairbourne **First Name** Timothy **Middle Initial** A.

Street Address 2320 W. 5400 S.

City/State/Zip Taylorsville/ UT/ 84129

Home Phone _____ **Cell / Message Phone** (801) 833-8753

Company/Employer CMG

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Are you legally authorized to work in the United States of America? ☒ YES ☐ NO

Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Timothy Fairbourne	*Timothy Fairbourne*	February 27, 2015
Name (Print or type)	Applicant's Signature	Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H 0

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2015

1 Your first name and middle initial	Last name	2 Your social security number
Timothy A.	Fairbourne	528-79-6882

Home address (number and street or rural route)
2320 W. 5400 S.

City or town, state, and ZIP code
Taylorsville, UT 84129

3 ☑ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5 0
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ► Timothy Fairbourne

Digitally signed by Timothy Fairbourne
DN: cn=Timothy Fairbourne, o, ou, email=timothyfairbourne@yahoo.com, c=US
Date: 2015.02.26 15:27:55 -07'00'

Date ► February 26, 2015

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details . . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er) / $9,250 if head of household / $6,300 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2015 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Fairbourne	Timothy	A.	

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
2320 W. 5400 S.		Taylorsville	UT	84129

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
04/02/1977	528-79-6882	timothyfairbourne@yahoo.com	833-8753

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☒ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*): 02/26/2015

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date (*mm/dd/yyyy*): 02/26/2015

Last Name (*Family Name*)	First Name (*Given Name*)
Fairbourne	Timothy

Address (*Street Number and Name*)	City or Town	State	Zip Code
2320 W. 5400 S.	Taylorsville	UT	84129

STOP ***Employer Completes Next Page*** STOP

STOP *Employer Completes This Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: Driver's License		Document Title: SS Card
Issuing Authority:		Issuing Authority: Utah		Issuing Authority: SS admin
Document Number:		Document Number: 153983274		Document Number: 528-79-6882
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*: 04/08/2019		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
[signature]	03/04/2015	Admin Assistant

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
Scholl	Caitlin	EMPLOYER SOLUTIONS STAFFING GROUP LLC

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
7301 OHMS LANE SUITE 405	EDINA	MN	55439

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

EMPLOYER SOLUTIONS STAFFING GROUP
IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Name:Timothy Fairbourne

Address:2320 W. 5400 S., Taylorsville, UT 84129

Home Phone:(801) 833-8753

Person(s) to contact in case of an emergency on the job (in order of preference):

1. **Name:** Kami Brundage

   Phone (work):

   Phone (home):(801) 332-0617

2. **Name:** Kerri Francom

   Phone (work):

   Phone (home):(801) 604-2025

Additional information you want Employer Solutions Group and our clients to know in the event of an emergency:

n/a

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen.

If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank.

Please allow until at least 10 am on your paydate for the deposit to show.

Please print

Check one of the following	Effective Date
Start-x	As Soon As Possible
Stop	
Change	Future Paydate 03/13/2015

Social Security Number 528-79-6882

Name (Last, First Middle Initial) Fairbourne, Timothy A.

Home Address Street 2320 W. 5400 S. City Taylorsville
State UT Zipcode 84129

Date (Mo/Day/Yr) 02/26/2015	Employee Signature Timothy Fairbourne	Daytime Phone Number (801) 833-8753

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.)

Type of Account

Checking Savings Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am **not** entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

STEP 1: You **MUST** complete the Employee Information Section as part of your new hire process.

Essential StaffCARE

Plan Information Packet

Please keep for your records.

STEP 2: You **MUST** Accept or Decline coverage.

PLEASE NOTE: Your Company has chosen to take some/all of your deductions on a Pre-Tax basis. Please contact Customer Service at 1-866-798-0803 and a Representative will assist you in identifying the deductions that are taken Pre-Tax.

Member Services:

Essential StaffCARE Customer Service: **1-866-798-0803**

- Once enrolled, members can call this number for questions regarding plan coverage, ID card, claim status, policy booklets, and to add, change, or cancel coverage.
- Customer Service Call Center hours are M - F, 8:30 a.m. to 8 p.m. Eastern Standard Time. Bilingual representatives are available.
- Members can also visit www.essentialcare.com/members and click on Essential StaffCARE.

STEP 3: You **MUST** Sign and Date here. Even if you decline coverage.

FREQUENTLY ASKED QUESTIONS

How do I enroll?

Enrolling in the Essential StaffCARE plan is easy. You can enroll by completing an Essential StaffCARE enrollment application and returning it to your manager.

When can I enroll in the plan?

As a full-time and/or part-time employee, you are able to enroll in the Essential StaffCARE program within 30 days of your hire date, 1st paycheck date, or your employer's annual 30 day open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

What is a qualifying life event?

A qualifying life event is defined as a change in your status due to one of the following:

- Marriage or divorce
- Birth or adoption of a child(ren)
- Termination
- Death of an immediate family member
- Medicare entitlement
- Employer bankruptcy
- Loss of dependent status
- Loss of prior coverage

In addition, you may request a special enrollment (for yourself, your spouse, and/or eligible dependents) within 60 days (1) of termination of coverage under Medicaid or a State Children's Health Insurance Program (SCHIP), or (2) upon becoming eligible for SCHIP premium assistance under this medical benefit.

Are dependents covered?

Yes. Eligible dependents include your spouse and your children up to age 26.

When does coverage begin?

Coverage will begin the Monday following a payroll deduction and continues as long as you have a deduction from your paycheck. Please review your check stub for deductions. If you miss a payroll deduction, to avoid a break in coverage, you may make direct payments to PAI. After six consecutive weeks without a payroll deduction or direct premium payment, coverage will be terminated and COBRA information will be sent at that time.

If I complete an enrollment form, but do not get placed on assignment right away, will I have to complete a new form?

After six months if there has not been a deduction from your paycheck, please fill out a new enrollment form. Missing information will delay the process.

Can I make changes or cancel coverage?

You may cancel or reduce coverage at any time unless your premiums are deducted pre-tax. You will only have 30 days from your hire date or first paycheck date to enroll, add additional benefits or add additional insured members. After this time frame, you will only be allowed to enroll, add benefits or add additional insured members during your annual open enrollment period or within 30 days of a qualifying life event.

(Please refer to the "PLEASE NOTE" section on the previous page to see if deductions are Post-Tax or Pre-Tax)

How can I make changes?

To make changes or cancel coverage by telephone call (800) 269-7783. Enter your PIN CODE plus the last four digits of your Social Security number (SSN).

PIN CODE: 142 + _ _ _ _
(last four digits of your SSN)

Remember, it may take up to two or three weeks for the changes or cancellation to be reflected on your paycheck. Coverage will continue as long as you have a paycheck deduction.

Is there a pre-existing clause for the Medical Benefit?

There are no restrictions for pre-existing conditions in this medical plan. Even if you were previously diagnosed with a condition, you can receive coverage for related services as soon as your coverage goes into effect.

Is there coverage for contraceptives on this plan?

Oral contraceptives are covered under the prescription benefit. Non-oral contraceptives are not covered.

Are maternity benefits covered?

Yes, maternity benefits are covered the same as any other condition under this plan.

BENEFITS AT A GLANCE

Policy Number 219301-EMP

Medical Benefits - Plan 2

Weekly Rates

Inpatient Benefits		Outpatient Benefits [1]	
Annual Inpatient Maximum	No Maximum	**Annual Outpatient Maximum**	$2,000
Daily Standard Care Maximum	$500 per day	**Physician Office Visit**	$100 per day
Daily Intensive Care Unit Maximum [2]	$600 per day	**Diagnostic Lab**	$75 per day
Surgery	$3,000 per day	**Diagnostic X-ray**	$200 per day
Anesthesiology	$600 per day	**Ambulance Services**	$300 per day
First Hospital Admission one per year	$250	**Physical, Occupational, and Speech Therapy**	$50 per day
Skilled Nursing payable for stays in a skilled nursing facility after a hospital stay	$100 per day	**Emergency Room - Sickness**	$200 per day
Prescription Drug [3]		**Emergency Room - Accident**	$500 per day
Prescription Drug Annual Maximum	$600	**Outpatient Surgery**	$500 per day
Prescription Drug Benefits	$20 per day	**Anesthesiology**	$200 per day

Wellness Care	
Wellness Care one per year	$100

Employee Only **$20.91** **Employee + One** **$42.44** **Employee + Family** **$56.67**

[1] all outpatient benefits are subject to the outpatient maximum [2] pays in addition to standard care benefit [3] not subject to outpatient maximum

Dental Benefits

Weekly Rates

	Waiting Period	Co-insurance	Annual Maximum Benefit $750	Deductible $50
Coverage A	None	100%	Exams, Cleanings, Intraoral Films and Bitewings	
Coverage B	3 months	60%	Fillings, Oral Surgery, and Repairs for Crowns, Bridges and Dentures	
Coverage C	12 months	50%	Periodontics, Crowns, Bridges, Endodontics and Dentures	

Employee Only **$5.99** **Employee + One** **$11.98** **Employee + Family** **$19.77**

Short-Term Disability

Weekly Rates

Benefit	60% of Salary up to $150 per week	**Waiting Period / Maximum Benefit Period**	7 days / 26 weeks

Employee Only **$4.20**

Term Life Benefits

Weekly Rates

Employee Amount	$10,000 (reduces to $7,500 at 65; $5,000 at age 70)	**Child Amount** (6 months to 26 years old)	$5,000
Spouse Amount	$5,000 (terminates at age 70)	**Infant Amount** (15 days to 6 months)	$1,000

Accidental Death and Dismemberment Benefit			
Employee Amount	$20,000	**Child Amount** (6 months to 26 years old)	$5,000
Spouse Amount	$20,000	**Infant Amount** (15 days to 6 months)	$2,500

Employee Only **$0.60** **Employee + One** **$0.90** **Employee + Family** **$1.80**

NETWORK INFORMATION

Prescription Drug Network

If enrolled in the medical plan, you are automatically covered by the prescription drug program through the Caremark Pharmacy Network. Caremark has a national network with over 58,000 participating pharmacies. To find a local participating Caremark pharmacy, you can visit www.caremark.com. Prescription drug benefit information can be found on the Benefits at a Glance page.

Stretch Your Benefit Dollars

This benefit plan offers you and your family savings for medical care through discounts negotiated with providers and facilities in the First Health Network. Choosing an in-network provider helps maximize benefits. When you use an in-network provider, you will automatically receive the network discount and the doctor's office will file the claim for you. If you use a doctor who is not part of the network, you will not receive the discount and you may need to file the claim yourself.

How Do I Locate a Doctor?

Enrolled members are encouraged to visit providers in the networks listed in order to maximize their benefit dollars. To find a participating provider or verify your current medical provider is in-network, please call or visit the network websites referenced on this page.

What if I need to have a prescription filled?

For generic and brand prescriptions, the plan pays you $20 per day up to the annual maximum, for drugs dispensed by a pharmacist. Prescription drug coverage is not provided for drugs administered during a physician office visit or hospital stay. If you choose a participating pharmacy and present your ID card, you will receive a discount off the retail price of the prescription at the time of purchase. Save your receipt to file a claim for reimbursement of the fixed dollar amount.

Do I have to go to an in-network provider?

It is not required that you go to an in-network provider. If you choose a provider who participates in the PPO network, you receive two key advantages:

- PPO discount for all services.
- The provider will file the claim to the plan.

Medical

- First Health Network
  1-800-226-5116
  www.firsthealth.com

Prescription

- Caremark
  1-888-963-7290
  www.caremark.com

Vision - (discount only)

- EyeMed Vision Care
  1-866-559-5252
  www.eyemedvisioncare.com

Dental

- DenteMax
  1-800-752-1547
  www.dentemax.com

Do not contact the above Networks for questions regarding your medical benefits. All medical benefit questions should be directed to the Essential StaffCARE Member Services line at 1-866-798-0803.

When should I expect an ID card?

ID cards will be mailed as soon as your enrollment form is received and processed. You should receive your ID card within 10 business days of your effective date.

Member ID Cards

An ID card and confirmation of coverage letter will be mailed to your home address. If you do not receive these documents within 10 business days of your effective date, or have a change of address, please contact the Essential StaffCARE Customer Service at **1-866-798-0803**. Present your ID card to the provider at the time of service. These ID cards are used for identification purposes and providers use them to verify eligibility status.

EXCLUSIONS AND LIMITATIONS

These are the standard limitations and exclusions. As they may vary by state, please see your summary plan description (SPD) for a more detailed listing.

MEDICAL

No benefits will be paid for loss caused by or resulting from:

- Intentionally self-inflicted injuries, suicide or any attempt while sane or insane;
- Declared or undeclared war;
- Serving on full-time active duty in the armed forces;
- The covered person's commission of a felony;
- Work-related injury or sickness, whether or not benefits are payable under workers' compensation or similar law;

No benefits will be paid for:

- Eye examinations for glasses, any kind of eye glasses, or vision prescriptions;
- Hearing examinations or hearing aids;
- Dental care or treatment other than care of sound, natural teeth and gums required on account of injury to the covered person resulting from an accident that happens while such person is covered under the policy, and rendered within 6 months of the accident;
- Services rendered in connection with cosmetic surgery, except cosmetic surgery that the covered person needs for breast reconstruction following a mastectomy or as a result of an accident that happens while such person is covered under the policy. Cosmetic surgery for an accidental injury must be performed within 90 days of the accident causing the injury and while such person's coverage is in force;
- Services provided by a member of the covered person's immediate family.

PRESCRIPTION DRUGS

No benefits will be paid for over-the-counter products or medications or for drugs and medications dispensed while you are in a hospital.

DENTAL

The plan will pay only for procedures specified on the Schedule of Covered Procedures in the group policy. Many procedures covered under the plan have waiting periods and limitations on how often the plan will pay for them within a certain time frame. For more detailed information on Covered Procedures or limitations, please see your summary plan description.

SHORT-TERM DISABILITY

No benefits are payable under this coverage in the following instances:

- Attempted suicide or intentionally self-inflicted injury;
- Voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you or your spouse, you or your spouse's child, sibling or parent; or a person who resides in your home;
- Declared or undeclared war or act of war;
- Your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony;
- Your participation in a riot;
- If you engage in an illegal occupation;
- Release of nuclear energy;
- Operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; or
- Work-related injury or sickness.

Short-Term Disability benefits are not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

TERM LIFE WITH ACCIDENTAL DEATH & DISMEMBERMENT

No Life Insurance benefits will be payable under the policy for death caused by suicide or self-destruction, or any attempt at it within 24 months after the person's coverage under the policy became effective.

For Accidental Death and Dismemberment benefits will not be payable for any loss caused in whole or in part by, or resulting in whole or in part from, the following:

Attempted suicide or intentionally self inflicted injury; bodily or mental infirmity; disease of any kind; or medical or surgical treatment for that infirmity or disease. This does not include bacterial infections resulting from an accidental cut or wound or accidental ingestion of poisonous food substance; voluntary taking of poison; voluntary inhalation of gas; voluntary taking of a drug or chemical. This does not apply to the extent administered by a licensed physician. The physician must not be you, your spouse or domestic partner; you, your spouse's or domestic partner's child; sibling or parent; or a person who resides in your home; declared or undeclared war or act of war; your commission of or attempt to commit a felony, or any loss sustained while incarcerated for the felony; your participation in a riot; if you engage in an illegal occupation; release of nuclear energy; operating, riding in, or descending from any aircraft (including a hang glider). This does not apply while you are a passenger on a licensed, commercial, nonmilitary aircraft; work-related injury or sickness.

VSI-IND 219301-EMP | OFFICE USE ONLY | ReHire Date ___/___/_____

EMPLOYEE INFORMATION (Must Be Filled Out) — ENROLLMENT FORM - PLAN 2

USE BLACK or BLUE INK ONLY
ESC CU(NAV*SAD) P2 v13.0

Social Security Number 528 - 79 - 6882

Date of Birth 04 / 02 / 1977 Sex [M] F

Name Timothy Fairbourne

Street Address 2320 W. 5400 S.

City Taylorsville State UT Zip 84129

Home Phone 801 - 833 - 8753

Do you or any dependents have Medicare?

☐ Yes ☒ No If Yes:

Medicare Health Insurance Claim Number (HICN) _____

Medicare Effective Date ___/___/_____

Names of Covered Person(s)

1. _____
2. _____
3. _____

BENEFIT SELECTION — Weekly Rates

MEDICAL

- [X] $20.91 Employee Only
- [ ] $42.44 Employee + One
- [ ] $56.67 Employee + Family
- [ ] **NO to MEDICAL, TERM LIFE, and STD benefits.**

DENTAL

- [X] $ 5.99 Employee Only
- [ ] $11.98 Employee + One
- [ ] $19.77 Employee + Family
- [ ] **NO**

TERM LIFE

- [ ] **YES** $0.60 Employee Only / $0.90 Employee + One / $1.80 Employee + Family
- [X] **NO**

SHORT-TERM DISABILITY

- [ ] **YES** $4.20 Employee Only
- [X] **NO**

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

You **MUST** enroll in the Medical Insurance Plan before adding Term Life or STD. Your coverage level for Term Life will be identical to your medical plan selection.

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex [M] F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex [M] F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

Name _____

Social Security Number ___-___-_____

Date of Birth ___/___/_____ Sex [M] F

Relationship: ☐ Spouse ☐ Child ☐ Domestic Partner

BENEFICIARY INFORMATION

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY

_____

RELATIONSHIP

_____

Accidental Death & Dismemberment is part of the Term Life Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declination of coverage.

▶ **Signature** Timothy Fairbourne Date 02 / 27 / 2015

Essential StaffCARE

Health Insurance Enrollment Form

Complete the Enrollment Form to Elect or Decline Coverage

- You **MUST** Complete the Enrollment Form for the New Hire Process
- You **MUST** Elect or Decline Medical Coverage on the Enrollment Form
- You **MUST** Sign the Bottom of the Form, even if you Decline Coverage
- Return the Enrollment Form to your Branch Manager
- Keep the Plan Information Packet for Your Records

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF INSURANCE FRAUD AND WILL BE PROSECUTED.

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For questions or assistance, please call Essential StaffCARE Customer Service at 1-866-798-0803.

The Essential StaffCARE Medical/Rx and Dental Plans are underwritten by BCS Insurance Company, Oakbrook Terrace, Illinois under Policy Series Numbers 25.204 and 26.212. The Term Life, Accidental Death and Dismemberment, and Short-Term Disability Plans are underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, Illinois under Policy Series Number 62.200.

Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen.

If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck. The time that the money goes into your account on pay day varies by bank.

Please allow until at least 10 am on your paydate for the deposit to show.

Please print

Check one of the following	Effective Date
Start	As Soon As Possible
Stop	
Change	Future Paydate 03/13/2015

Social Security Number- 528-79-6882

Name (Last, First Middle Initial) Fairbourne, Timothy A.

Home Address Street 2320 W. 5400 S. City Taylorsville
State UT Zipcode 84129

02/27/2015	Timothy Fairbourne	(801) 833-8753

SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.)

Type of Account

Checking Savings **Money Market Checking** Money Market Investment Requires Submission of ACH form from your broker

I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am **not** entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

To: All Employees
Quien: *Todos Empleados*

From: Corporate Management Group & Employer Solutions Group
De: *Corporate Management Group y Employer Solutions Group*

Re: Stop Payment Check Fee
Re: *Tarifa de cheque parado*

Effective immediately, to replace a lost or stolen check, $50.00 will be deducted from the replacement check for a stop payment fee and for a reprocessing fee. *Efectivo inmediatamente, para reemplazar un cheque de sueldo perdido o robado, $50.00 de tarifa sera deducido de el cheque reemplazado para parar el cheque original y para procesarlo denuevo.*

If you lose your check, we will first have to verify that it has not been processed through the bank. If it has not, a new check will be issued, minus the $50.00 fee. *Si usted pierde su cheque, tendremos que verificar que no ha sido procesado en el banco. Si no, un cheque nuevo sera processado, menos las tarifa de $50.00.*

If your check is stolen, we will first need a copy of the police report before a new check can be reissued. After we receive a copy of the police report, a new check will be issued following the same procedures as listed above. *Si su cheque es robado, necesitaremos una copia de el reporte de policia antes de que un cheque nuevo sera procesado. Despues de obtener una copia del reporte de policia, un cheque nuevo sera procesado usando los mismos procedimientos mencionados arriba.*

If you have any questions regarding this new policy, please contact your On-Site Representative or the Corporate Office (303-920-1425). *Si usted tiene preguntas sobre esta poliza, por favor contacte a su representante de CMG o la oficina corporal al (303-920-1425)*

Thank you for your continued dedication and hard work!

Gracias por su dedicacion continua!

By signing below you are confirming that you understand the above policy.
Con su firma abajo usted esta confirmando que entiende la poliza descrita.

Signature/*Firma*: Timothy Fairbourne
Date/*Fecha*: February 27, 2015

DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF BACKGROUND REPORTS

It is recognized and understood that the Fair Credit Reporting Act provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses" shall be fined not more than $2,500 or imprisoned not more than a year, or both.

In connection with my application for EMPLOYMENT (including contract for services), I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle, and other reports. These reports may include information as to my character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further, I understand that you will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences. *If I include a current employer for verification, I may jeopardize my position within that company.* I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from any liability and responsibility for doing so. I hereby consent to obtaining the above information from BACKGROUND SOURCE INT'L and/or any of their licensed agents. This authorization and consent shall be valid in original, fax or copy form. I further authorize ongoing procurement of the above mentioned reports at any time during my employment (or contract).

Applicant Signature: Timothy Fairbourne (Timothy Fairbourne (Feb 19, 2015)) **Date:** February 19, 2015

Please PRINT clearly: Position applied for: Inventory Assistant

Name: Timothy (First) Alan (Middle) Fairbourne (Last) Maiden / AKA: _____

Soc. Sec. #: 528-79-6882 *Sex: M *Race: white *Date of Birth: April 2, 1977

Current Address: 2320 w. 5400 s. County: Salt Lake

City: Taylorsville State: UT Zip: 84129 How long: _____ to _____

Previous Address: _____ County: _____

City: _____ State: _____ Zip: _____ How long: _____ to _____

Motor Vehicle Report **Fax to: (208)769-7282**

Name as it appears: Timothy Fairbourne License #: 153983274 State held: UT

*Responses to these are completely voluntary. You need not respond to have your application considered. However, without this information, we may be unable to distinguish you from another in the event we discover adverse information during our background investigation. 03/06/01

Form **8850** (Rev. January 2012)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

▶ See separate instructions.

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name Timothy Fairbourne Social security number ▶ 528-79-6882

Street address where you live 2320 w. 5400 s.

City or town, state, and ZIP code Taylorsville, UT 84129

County Salt Lake Telephone number (801) 833-8753

If you are under age 40, enter your date of birth (month, day, year) April 2, 1977

1 ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  a Received SNAP benefits (food stamps) for the past 6 months, **or**
  b Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

3 ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

4 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

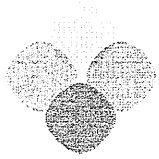
5 ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

6 ☐ Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years, **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ▶ Timothy Fairbourne **Date** March 2, 2015



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STATEMENT OF CONFIDENTIALITY

This agreement made this 2nd day of March, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Timothy Fairbourne hereafter referred to as "employee".

WITNESSETH:

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of $10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

Timothy Fairbourne

Employee Signature

Employer Solutions Staffing Group LLC, Representative

Background Investigation Information Release Form

Please read this form carefully and be aware that by allowing Employer Solutions Staffing Group LLC to investigate your background with state and federal agencies, you will be waiving and releasing all claims for damages you might sustain arising out of the criminal and driving record background check and review.

I understand that a successful criminal and driving record background investigation is a condition of my employment by Employer Solutions Staffing Group LLC to work at facilities of:

_____,

and, further, that Employer Solutions Staffing Group may, at its discretion, conduct periodic criminal and driving record background investigations on me during the course of my employment with Employer Solutions Staffing Group.

I agree to waive and relinquish all claims I may have against Employer Solutions Staffing Group LLC and its officers, agents, servants and employees as a result of my participation in any criminal and driving record background investigation.

I do hereby fully release and discharge Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims from damages that I may have or that may accrue to me on account of the results of any aspect of any criminal and driving record background investigation.

I further agree to indemnify and hold harmless and defend Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims resulting from damages sustained by me or arising out of, connected with, or in any way associated with, any of the activities of any criminal and driving record background investigation and review.

I have read and fully understand this Waiver and Release of All Claims.

528-79-6882	153983274	UT
Social Security Number	Driver's License No:	State
Fairbourne	Timothy	A.
Last Name	First Name	M.I

Maiden and/or Other Last Names Used

2320 w. 5400 s.	Taylorsville and Salt Lake	UT and 84129
Current Address	City and County	State and Zip Code
April 2, 1977	Circle One: Male / Female	
Date of Birth		

Signature: Timothy Fairbourne Date: March 2, 2015

Form A (rev. 08/12)

TAX CREDIT QUESTIONNAIRE

RETROTAX
Specialists in Tax Credit Administration

EMPLOYER SECTION:

ESG FEIN#:	ESG Client Name & State:	
Hiring Manager:	Position:	Starting Wage: $

EMPLOYEE SECTION:

Employee Name:	Street Address:		City/State:	Zip:
Timothy Fairbourne	2320 w. 5400 s.		Taylorsville	UT
SS#: 528 - 79 - 6882	**Date of Birth:** 04 / 02 / 1977	**Age:** 37	**Have you worked for this company before?** ☐ Yes ☒ No	**If yes, location:**

Please complete all questions, and sign and date the form. Yes No

1. **Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997?** (If yes, please provide information below.) ☐ ☒
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

2. **Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?** ☐ ☒
   (If yes, please provide information below.)
   Name of the person receiving benefits: _____ Relationship to you: _____
   City: _____ County: _____ State: _____

3. **Have you received Supplemental Security Income (SSI) at any time within the past 3 months?** ☐ ☒
   Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.
   **If you checked yes please provide a copy of your SSI documentation.*

4. **Have you received any type of vocational rehabilitation services within the past two years?** ☐ ☒
   If yes, please indicate which type of agency you worked with and provide their location information below:
   ☐ Vocational Rehabilitation Agency ☐ Dept. of Veterans Affairs ☐ Employment Network (Ticket to Work Program)
   Name of Agency: _____ Phone #: _____
   City: _____ County: _____ State: _____
   **If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*

5. **Are you a Veteran of the U.S. Military?** **If yes, please provide a copy of your DD-214 and letter of separation.* ☐ ☒
   (If yes, please provide information below. If no, please continue to question #6.)
   Dates of Service - From: ____/____/____ To: ____/____/____
   Branch of Service: _____
   Are you entitled to or are you receiving compensation for a service-connected disability? ☐ ☒
   Have you been unemployed at any time during the last 12 months? ☐ ☒
   If yes, dates of unemployment - From: ____/____/____ To: ____/____/____
   Did you receive unemployment compensation at any point during your unemployment? ☐ ☒

6. **Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?** ☐ ☒
   Conviction Date: ____/____/____ Release Date: ____/____/____
   Was this a ☐ Federal or ☐ State conviction? If State - County: _____ State: _____

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe? ☐ ☒
**If you checked yes please provide a copy of your CDIB card.*

CA Residents: ☐ Are you the child of foster parents? ☐ Do you receive CalWorks? ☐ Workforce Investment Act?
☐ Are you a migrant or seasonal farm worker? ☐ Have you ever been convicted of a misdemeanor?

SC Residents: ☐ Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba Retrotax), or the Department of Labor.

New Employee Signature: Timothy Fairbourne **Date:** March 2, 2015

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INJURY MANAGEMENT PROGRAM

Injured Worker's Responsibilities

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

RESPONSIBILITIES OF THE INJURED WORKER:

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

I have read my responsibilities and agree to abide by these guidelines.

Signed: Timothy Fairbourne

Printed Name: Timothy Fairbourne

employer solutions staffing group, LLC

Leveraging Resources in a Changing Market

Important/Importante

LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between $25-$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre $ 25 - $ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Timothy Fairbourne

Signature/Firma: Timothy Fairbourne

528-79-6882

THIS NUMBER HAS BEEN ESTABLISHED FOR

TIMOTHY A FAIRBOURNE

SIGNATURE

UT
USA

Utah DRIVER LICENSE

4d 153983274 4a Iss 04/15/2014

1 FAIRBOURNE

2 TIMOTHY ALAN

3 DOB 04/02/1977

8 2320 W 5400 S
TAYLORSVILLE, UT 84129

5 DD 1 T 4b Exp 04/02/2019

9 Class D 9a End

12 Restrictions A

DONOR N 16 Hgt 6'02" 18 Eyes BLU

15 Sex M 17 Wgt 170 19 Hair BRO

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security **Report Prepared: 03/04/2015**

E-Verify **Page: 1 of 1**

Case Verification Number: 2015063101107JT

Case Information:

Employee Information:

Last Name:	Fairbourne	First Name:	Timothy
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 6882	Date of Birth:	04/04/1977
Citizenship Status:	A citizen of the United States	Email Address:	

Document Information:

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	Utah
Driver's License or ID Card Number:		Document Expiration Date:	04/02/2019
Alien Number:		I-94 Number:	

Additional Information:

Hire Date:	03/02/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CSCH4411	Submitted On:	03/04/2015

Initial Case Result:

Case Result: Employment Authorized

Employee Referred to SSA:

Referred By: Referred On:

Case Result from SSA (after SSA Tentative Nonconfirmation):

Case Result: Response Date:

Resubmitted to SSA (after Review and Update Employee Data):

Last Name:	First Name:
Middle Initial:	Other Names Used:
Social Security Number:	Date of Birth:
Resubmitted By:	Resubmitted On:

Case Result from SSA (after Resubmission):

Case Result:

Request Name Review:

Comments:

Submitted By: Submitted On:

Case Result from DHS (after DHS Verification in Process):

Case Result: Response Date:

Employee Referred to DHS:

Referred By: Referred On:

Case Result from DHS (after DHS Tentative Nonconfirmation):

Case Result: Response Date:

Photo Matching Results:

Determination:

Employee Referred to DHS (Additional):

Referred By: Referred On:

Case Result from DHS (after Additional DHS Tentative Nonconfirmation):

Case Result: Response Date:

Case Closure:

Closure Statement:
Closed By: Closed On:

SENSITIVE BUT UNCLASSIFIED